

CHAPTER 10

MEDICAID STATE PLAN SERVICES

CHILDREN'S PERSONAL CARE
INCONTINENCE SUPPLIES (UNDER 21)

Children's Personal Care Aide (CPCA) Services

Children's Personal Care Aide Services (CPCA) are available to Medicaid eligible children under age 21 who meet established medical necessity criteria. To qualify for CPCA services a child must meet the Service Needs Requirement and have one of the Functional deficits listed below:

Functional Deficits*

1. Requires extensive (hands on) assistance with bathing and dressing and toileting and feeding if otherwise age appropriate** functioning would normally allow these activities. (All four must be present and constitute one deficit).
2. Requires extensive (hands on) assistance with walking or wheelchair locomotion if these are otherwise age appropriate activities**.
3. Requires extensive (hands on) assistance with transfer if otherwise age appropriate activity**.
4. Requires extensive (hands on) assistance with daily incontinence care (if continence is otherwise age appropriate**) or with daily catheter or ostomy care.

* For infants ages 0-1, functional deficits generally will not apply. Medical necessity is based on Service Needs Requirement only.

** For children 0-5 years of age, Attachment A-"Guide to Developmental Stages of Children" may be used to determine age-appropriate activity.

Note: To receive CPCA services, a child must meet the Service Needs Requirements and have at least one (1) Functional Deficit.

Children's Personal Care services are not intended to supplant care provided by the parents/family or other natural/legal caregivers.

Service Needs Requirement

A physician must certify that the child requires daily monitoring and observation due to medical needs which could result in complications and that the services of a Personal Care Aide are required and intended to maintain the child's optimum health status.

CPCA Services are designed to help with normal daily activities and to monitor the medical conditions of the child. Aides providing this service may assist with ambulation/walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. In addition to the hands-on care provided to the child, aides may also help to maintain the child's home environment by performing light cleaning, laundry for the child, and tasks to keep the home safe for the child but these tasks may not be performed as discrete activities.

Aides work under the supervision of an RN or LPN but may not perform any type of skilled medical services. Aides may observe the child's vital signs such as respiratory rate, pulse rate, and temperature.

During the provision of the CPCA services, aides must be actively engaged in the completion of allowable tasks determined by the Case Manager to be needed. The provision of this service does not include supervision of the child ("childcare") as a discrete task nor does it include down-time between tasks or time waiting for a task to be needed.

A personal care aide is not allowed to render services in a school setting or during homebound instruction. CPCA must be provided in the recipient's home.

The unit of service is 15 minutes of service provided by one PCA.

Please see: Scope of Services for Personal Care 2 (PC II) Services

Providers: CPCA Services must be provided to children by an agency enrolled with the Department of Health and Human Services.

Arranging for and authorizing the service: When a child is believed to have needs that can be met through the provision of CPCA Services, access to those services may be obtained in one of two ways:

1. For children who are **NOT ENROLLED** in the Department of Disabilities and Special Needs (DDSN) Intellectual Disability/Related Disabilities (ID/RD) Waiver or Community Supports (CS) Waiver, access to CPCA is gained by referring the child to the Community Long Term Care (CLTC) area office in the child's area. If a physician determines a child qualifies for CPCA service, CLTC area office staff will conduct the assessment of need and authorization for service.
2. For children who are **ENROLLED** in either the ID/RD Waiver or CS Waiver, if a physician determines the child qualifies for CPCA services, the assessment of need and authorization of services is made by the child's Service Coordination/Early Intervention. The Case Manager will obtain a physician's order using the attached MSP Form 1 and complete the SCDDSN Personal Care/Attendant Care Assessment.

Service Approval: Initially and thereafter during plan review, all children enrolled in the ID/RD or CS Waiver **must have submitted a new Physician's Order Form and CPCA Request for review. Once reviewed and units approved, an initial authorization is required. Thereafter, a new authorization is only required if units are being changed** (see MSP forms/attachments). For children meeting both the "Service Needs Requirement" **and** who have a "Functional Deficit", Case Managers may authorize up to 10 hours (40 units) per week without additional prior approval. If the request indicates a need for services in excess of 10 hours (40 units) per week, **prior** authorization from SCDDSN Waiver Administration Division must be obtained and must be reviewed each year at the time of planning. Requests must:

- specifically explain need/reason for the amount of service
- include the completed screening and request forms
- include the proposed schedule for service delivery
- include supporting medical documentation
- be submitted to the SCDDSN Waiver Administration Division

Under no circumstances shall any amount more than 10 hours (40 units) per week be authorized without prior approval from DDSN. The requests must be reviewed by the SCDDSN Waiver Administration Division. Written documentation supporting this approval must remain in the participant record.

NOTE: CPCA Services should not be included in the Waiver budget.

NOTE: If the completed physician's order or CPCA screening or CPCA request indicates that either no service is needed or a reduced amount of service is needed, the Case Manager must issue a Notice of Termination/Reduction or Suspension at least ten (10) working days prior to the actual termination/reduction of the service. The reconsideration/appeals process must be attached.

Once the Case Manager has assessed the amount of services needed, obtained a Physician's order, and, if applicable, obtained approval from SCDDSN, the parents/guardian should be given a listing of available Personal Care providers from which to choose. This offering of provider choice must be documented. Once the service is approved and a Personal Care provider is selected, the Case Manager should complete the Authorization for CPCA Services (MSP Form 3) and send a copy to the chosen agency. This authorization remains in effect until a new/revised Authorization for CPCA Services is sent or until services are terminated. **The physician's order must be attached to the authorization.**

Monitoring Services: Because CPCA is not a waiver service, the Case Manager need only monitor CPCA as part of routine "Plan Review".

Reduction, Suspension or Termination of Services: If services are to be reduced, suspended or terminated, a written notice must be sent to the parent/guardian including the details regarding the change(s) in service, the allowance for appeal, and a ten (10) calendar day waiting period (from the date that the reduction/suspension/termination form is completed and sent to the parent/guardian) before the reduction, suspension or termination of the waiver service(s) takes effect. The attached MSP Form 4 will be used to reduce, suspend or terminate the service when applicable.

NOTE: When a child turns 21 years old, CPCA Services can no longer be received as a State Plan Medicaid Service. Please refer to the Enrollments Chapter/information from the appropriate Waiver manual for instruction on how to transition a child from CPCA services to waiver funded Personal Care Services.

If a child who is receiving CPCA Services is disenrolled from the ID/RD or Community Supports Waiver and will continue to need CPCA services, a referral must be made immediately to the CLTC office in the child's county area. Contact the DDSN Central Office Waiver Coordinator if assistance is needed for transition.

Guide to Developmental Stages of Children**1 month**

- Makes crawling movements when prone
- When held in standing position, body limp at knees and hips
- In sitting position back is uniformly rounded, absence of head control

2 months

- Turns from side to back
- When prone, can lift head almost 45 degrees off table
- When held in sitting position, holds head up but head bobs forward

3 months

- Holds head high, makes crawling movements when prone
- Able to hold head more erect when sitting, but still bobs forward
- When held in standing position, able to bear slight fraction of weight on legs
- Supports weight on forearms
- Able to raise head and shoulders from prone position to 45-90 degree angle from table
- Opens hand spontaneously

4 months

- Rolls from back to side
- Able to sit erect if propped up
- Supports weight on feet briefly with underarm support

6 months

- When held in standing position, bears almost all of weight
- Sits with support
- Lifts legs high, holds them out straight

7 months

- Bears full weight on feet
- Rolls over easily
- Sits without support
- Pushes up on hands and knees and rocks

8 months

- Readily bears weight on legs when supported, may stand holding onto furniture
- Crawls on belly – arms used to pull body forward

9 months

- Crawls, may progress backward at first
- Sits steadily on floor for prolonged time (10 minutes)
- Pulls self to standing position and stands holding onto furniture
- Makes stepping movements

10 months

- Pulls self up
- Can hold bottle and feed self crackers
- Can drink from cup
- Crawls by pulling self forward with hands
- Pulls self to sitting position
- Stands while holding onto furniture, sits by falling down

12 months

- Begins to stand alone and toddle
- Uses spoon
- Cruises or walks holding onto furniture or with hand held
- May attempt to stand alone momentarily
- Can sit down from standing position without help

15 months

- Walks without help (usually since age 13 months)
- Creeps up stairs
- Assumes standing position without support
- Uses cup well

- Feeds self with regular cup with little spilling

18 months

- Runs clumsily, falls often
- Walks upstairs with one hand held
- Seats self on chair
- Manages spoon, but some spilling
- Takes off gloves, socks, and shoes and unzips

24 months

- Walks up and down stairs, has steady gait
- Holds cup for drinking
- Feeds self with spoon
- Cooperates with toilet training
- Runs fairly well, with wide stance
- Dresses self in simple clothing
- Participates in bathing

3 years

- Undresses self, washes and dries hands
- Feeds self with spoon
- May attend to toilet needs without help except for wiping
- Buttons and unbuttons accessible buttons
- Pulls on shoes
- Should have achieved daytime bowel and bladder control with occasional accidents

4 years

- Buttons front and side of clothes
- Bathes self with directions

5 years

- Has good motor control
- Washes self
- Cares for self totally, occasionally needing supervision in dress or hygiene
- Should have achieved daytime and nighttime bowel and bladder control

Revised 10/7/09

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CHILDREN'S PERSONAL CARE AIDE (PCA)
PHYSICIAN INFORMATION FORM**

CHILD'S NAME: _____

SECTION I – MEDICAL INFORMATION

DATE OF LAST OFFICE VISIT: _____

DIAGNOSIS: _____

CURRENT PHYSICAL CONDITION AND LIMITATIONS: _____

CURRENT MEDICATIONS AND TREATMENT PLAN: _____

SECTION II – THE INFORMATION IN THIS SECTION IS REQUIRED IN ORDER TO DETERMINE IF THE CHILD QUALIFIES FOR THIS SERVICE.

SERVICE NEED: (CIRCLE ONE)

YES NO THE INDIVIDUAL REQUIRES DAILY MONITORING AND OBSERVATION DUE TO MEDICAL NEEDS WHICH COULD RESULT IN MEDICAL COMPLICATIONS. THE MEDICAL NEEDS ARE DOCUMENTED, AND THE SERVICES OF A PERSONAL CARE AIDE ARE REQUIRED AND INTENDED TO MAINTAIN OPTIMUM HEALTH STATUS. **(NOTE: A PERSONAL CARE AIDE CANNOT PERFORM ANY SKILLED TASKS)**

PLEASE SPECIFY:

HOW LONG WOULD YOU EXPECT PCA SERVICES TO BE NEEDED?

☐ 3 MONTHS ☐ 6 MONTHS ☐ 9 MONTHS ☐ 12 MONTHS ☐ INDEFINITE

PLEASE CONTINUE ON REVERSE SIDE OR NEXT PAGE

SECTION III

PLEASE CHECK BELOW ALL SPECIFIC CARE NEEDS NECESSARY FOR THIS CHILD AND INDICATE THE FREQUENCY:

<u>SPECIAL CARE OR TREATMENT</u>		<u>FREQUENCY</u>	<u>DIETARY</u>		<u>FREQUENCY</u>
<input type="checkbox"/>	MONITOR MEDICATIONS		<input type="checkbox"/>	TUBE FEEDING	
<input type="checkbox"/>	CATHETER/OSTOMY		<input type="checkbox"/>	SPECIAL DIET	
<input type="checkbox"/>	VITAL SIGNS		<input type="checkbox"/>	TYPE:	
<input type="checkbox"/>	SAFETY		COMMENTS:		
<input type="checkbox"/>	VENTILATOR				
<input type="checkbox"/>	TRACHEOSTOMY				
<input type="checkbox"/>	SUCTIONING				
<input type="checkbox"/>	OTHER (SPECIFY)				

PHYSICIAN SIGNATURE_____
DATE

PHYSICIAN NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

**S. C. DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
Medicaid State Plan Services for Children in a HCB Waiver**

**AUTHORIZATION FOR CHILDREN'S PERSONAL CARE SERVICES
TO BE BILLED TO SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

TO: _____

You are hereby authorized to provide

☐ Personal Care II (T1019) for:

Participant's Name: _____

Date of Birth: _____ (must not be 21 or older)

Address: _____

Phone Number: _____

Medicaid #: _____

Social Security #: _____

Only the number of units rendered maybe billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Start Date: _____

Authorized Total – Children's PCA ____ **Units per week (1 unit = 15 minutes)**

Service Tasks Requested:

- ☐ Assistance with personal care activities such as bathing, dressing, toileting, brushing teeth, grooming, shampooing hair, caring for skin, etc.
- ☐ Assistance with meals such as feeding, preparing/cooking meals, post-meal cleanup, etc.
- ☐ Assistance with home care/light housekeeping tasks such as sweeping, light laundry, bed making, changing bed linens, etc.
- ☐ Monitoring conditions such as temperature, checking pulse rate, observation of respiratory rate, checking blood pressure, monitoring medications, etc.
- ☐ Assistance with exercise, locomotion, positioning, etc.

Please note: Physician's order is attached.

Service Coordination Provider: _____ **Case Manager Name:** _____

Address: _____

Phone #: _____

Signature of Person Authorizing Services

Date

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
NOTICE OF TERMINATION, REDUCTION, DENIAL OR SUSPENSION OF MEDICAID STATE PLAN SERVICE**

To: _____
LEGAL GUARDIAN/PARENT OF WAIVER PARTICIPANT

AND

SERVICE PROVIDER AGENCY/COMPANY

Re: _____
CHILD'S NAME DATE OF BIRTH

MEDICAID ID NUMBER

EFFECTIVE _____, THE FOLLOWING **MEDICAID STATE PLAN SERVICE**:

DATE

- ☐ **CHILDREN'S PERSONAL CARE**
☐ **CHILDREN'S STATE PLAN NURSING**

IS BEING: ☐ **TERMINATED:** _____
☐ **REDUCED:** A NEW AUTHORIZATION WITH ADJUSTED UNITS WILL BE ISSUED
☐ **SUSPENDED:** AUTHORIZATION WILL BE ISSUED WHEN SERVICES CAN BEGIN
☐ **DENIED:** _____

ONLY UNITS OF SERVICE RENDERED PRIOR TO OR ON THE EFFECTIVE DATE NOTED ABOVE MAY BE BILLED.

SIGNATURE OF CASE MANAGER PRINT NAME

DATE OF ISSUE/SIGNED: _____

SC CONTACT INFORMATION: _____

AGENCY

PHONE NUMBER

SCDDSN RECONSIDERATION PROCESS

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability-Related Disabilities (ID-RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver, and the Pervasive Developmental Disorder (PDD) Waiver. If a Waiver participant disagrees with a decision made and/or action taken by SCDDSN, reconsideration and reversal of the adverse decision/action may be requested.

The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal with the South Carolina Department of Health and Human Services (SCDHHS), which is the State Medicaid Agency.

A request for a SCDDSN reconsideration of an adverse decision/action must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If the adverse decision/action was in response to a request to exceed service limits, evidence of the medical necessity of the services must be included in the request and will be considered by SCDDSN. If necessary, a Case Manager or other staff may assist the participant, legal guardian or representative in requesting reconsideration. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to:

**State Director
SC Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240**

The State Director or a designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and mail it to the participant, legal guardian or representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written notification.

Note: In order for affected Waiver services to continue during the SCDDSN reconsideration process and the SCDHHS Medicaid appeal process, the participant, legal guardian or representative's request for SCDDSN reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of the affected Waiver services must be specifically requested in the request for SCDDSN reconsideration. If the adverse decision/action is upheld, the participant or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes.

SCDHHS MEDICAID APPEAL PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process above and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS).

The appeal request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than thirty (30) calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS administrative appeal is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a Waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The participant, legal guardian or representative is encouraged to file the appeal electronically at www.scdhhs.gov/appeals.

OR

The appeal request may be mailed to:

**SC Department of Health and Human Services
Division of Appeals and Hearings
P.O. Box 8206
Columbia, SC 29202-8206**

An appeal request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the thirtieth (30th) calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding.

If a valid appeal request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.

A beneficiary may request an expedited appeal. SCDHHS will grant or deny these requests as quickly as possible. If we grant your request to expedite, your appeal will be resolved as quickly as possible instead of the standard 90-day timeframe. If we deny the request to expedite, the appeal will follow the standard 90-day timeframe.

SCDHHS may grant expedited review if we determine the standard appeal timeframe could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:

- the medical urgency of the beneficiary's situation
- whether a needed procedure has already been scheduled
- whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
- whether other insurance will cover most of the costs of the requested treatment.

You may request an expedited appeal at the same time you file your appeal request or after you file an appeal. Please state you are requesting an expedited appeal and explain why.

To avoid delays in the process, please submit any supporting documentation with the request for expedited review or immediately thereafter. While supporting documentation is not required, SCDHHS will make its determination based on the information made available at the time we consider the request.

Medicaid State Plan **Incontinence Supplies (Under 21)**

Incontinence Supplies are available to Medicaid eligible children under age 21 who meet established medical necessity criteria.

Providers: Incontinence supplies must be provided by licensed vendors enrolled with SCDHHS as Incontinence Supply provider.

Covered Supplies: Medicaid State Plan offers the following incontinence supplies based on medical necessity:

- ❖ One (1) case of diapers or briefs [1 case = 96 diapers or 80 briefs]
- ❖ One (1) case of incontinence pads/liners [1 case = 130 pads]
- ❖ One (1) case of under pads
- ❖ One (1) box of wipes
- ❖ One (1) box of gloves

Note: Requests for additional supplies will be considered on a case by case basis **and** if medical necessity is justified.

Criteria: The following criteria must be met for children to receive incontinence supplies:

1. The child must be between ages 4 - 20.
2. The child's inability to control bowel or bladder function must be confirmed by a Physician on the **Physician Certification of Incontinence (DHHS Form 168IS)**.
3. The Case Manager must conduct an assessment to determine the frequency and amount of supplies authorized.

Arranging for the Service: Once the child's need has been identified and documented in the plan and in the participant record, you must determine if the individual is eligible for incontinence supplies by having a physician complete the **Physician Certification of Incontinence (DHHS Form 168IS)**. This form must be completed annually. Upon completion of the physician certification, you must conduct a telephone assessment to determine the frequency of incontinence and the amount of supplies to be authorized. The frequency definitions are as follows:

Occasionally Incontinent =

- Bladder—Not daily. Approximately 2 or less times a week
- Bowel—Approximately once a week

Frequently Incontinent =

- Bladder—Approximately between 3 to 6 times a week, but has some control OR if the client is being toileted (w/extensive assistance) on a regular schedule.
- Bowel—Approximately between 2 to 3 times a week.

Totally Incontinent =

- No control of bladder or bowel

NOTE: If the child has an ostomy or catheter for urinary control and an ostomy for bowel control, only under pads may be authorized.

NOTE: If the child has an appliance for bowel or bladder control, diapers may be authorized based on the frequency of incontinence.

When conducting the assessment, you should determine the number of diapers used on average per day to calculate the number of cases of diapers and other supplies needed per month. This should be thoroughly recorded in service notes to justify the need. The participant's Support Plan must be updated to include the amount, frequency and duration. The SCDDSN Waiver Administration Division will review the request.

Once approved, the Case Manager must complete an **Authorization for Incontinence Supplies (Form IS-3)** and send it to the participant's provider of choice. The participant/Legal Guardian must be given a choice of providers of this service and offering choice must be documented. A copy of the authorization must remain in the participant's file. **FOR PARTICIPANT'S UNDER AGE 21, DO NOT ADD INCONTINENCE SUPPLIES TO THE BUDGET.**

Note: An authorization for wipes is based on the presence of an incontinence need only; therefore, an individual **must also be receiving** diapers and/or under pads in order to receive wipes. Wipes cannot be authorized for cosmetic or other general hygiene purposes. They can only be authorized for the participant's incontinence care.

Monitoring Services: Because Incontinence Supplies for children is not a waiver service, you need only monitor as part of the routine "Plan Review".

SCDDSN RECONSIDERATION PROCESS

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The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal with the South Carolina Department of Health and Human Services (SCDHHS), which is the State Medicaid Agency.

A request for a SCDDSN reconsideration of an adverse decision/action must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If the adverse decision/action was in response to a request to exceed service limits, evidence of the medical necessity of the services must be included in the request and will be considered by SCDDSN. If necessary, a Case Manager or other staff may assist the participant, legal guardian or representative in requesting reconsideration. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to:

**State Director
SC Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240**

The State Director or a designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and mail it to the participant, legal guardian or representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written notification.

Note: In order for affected Waiver services to continue during the SCDDSN reconsideration process and the SCDHHS Medicaid appeal process, the participant, legal guardian or representative's request for SCDDSN reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of the affected Waiver services must be specifically requested in the request for SCDDSN reconsideration. If the adverse decision/action is upheld, the participant or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes.

SCDHHS MEDICAID APPEAL PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process above and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS).

The appeal request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than thirty (30) calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS administrative appeal is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a Waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The participant, legal guardian or representative is encouraged to file the appeal electronically at www.scdhhs.gov/appeals.

OR

The appeal request may be mailed to:

**SC Department of Health and Human Services
Division of Appeals and Hearings
P.O. Box 8206
Columbia, SC 29202-8206**

An appeal request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the thirtieth (30th) calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding.

If a valid appeal request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.

A beneficiary may request an expedited appeal. SCDHHS will grant or deny these requests as quickly as possible. If we grant your request to expedite, your appeal will be resolved as quickly as possible instead of the standard 90-day timeframe. If we deny the request to expedite, the appeal will follow the standard 90-day timeframe.

SCDHHS may grant expedited review if we determine the standard appeal timeframe could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:

- the medical urgency of the beneficiary's situation
- whether a needed procedure has already been scheduled
- whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
- whether other insurance will cover most of the costs of the requested treatment.

You may request an expedited appeal at the same time you file your appeal request or after you file an appeal. Please state you are requesting an expedited appeal and explain why.

To avoid delays in the process, please submit any supporting documentation with the request for expedited review or immediately thereafter. While supporting documentation is not required, SCDHHS will make its determination based on the information made available at the time we consider the request.

AUTHORIZATION FOR SERVICES **SC MEDICAID STATE PLAN INCONTINENCE SUPPLIES**

TO: _____

RE: _____

Individual's Name
Date of Birth
Address
Phone #
Medicaid #

_____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ / _____ /

NOTE: The provider is responsible for pursuing all other resources prior to accessing Medicaid. State Plan Medicaid resources must be exhausted before accessing the Community Supports Waiver. Our information indicates this person has:

☐ Medicaid

☐ 3rd Party liability (private insurance)

☐ Medicare

You are hereby authorized to provide the following service(s) to the person named above. Only the number of units rendered may be billed. Please note: This nullifies any previous authorization to this provider for this service(s).

Prior Authorization # **C S** _____ / _____ / _____ / _____ /

 _____ **Diapers/each** **Start Date:** _____

 Size: ☐ Adult Small (T4521) ☐ Adult Medium (T4522) ☐ Adult Large (T4523)

☐ Adult X-Large (T4524) ☐ Adult Bariatric (T4543)

☐ Child Small/Medium (T4529) ☐ Child Large (T4530) ☐ Youth (T4533)

 Number of Diapers: _____ Per ☐ **Month**

 _____ **Briefs/each** **Start Date:** _____

☐ Adult Brief /Ex. Lrg (T4528) ☐ Adult Brief / Lrg (T4527) ☐ Adult Brief /Med. (T4526)

☐ Adult Brief /Sm. (T4525) ☐ Youth Brief (T4534) ☐ Child Brief Small (T4531)

☐ Child Brief Large (T4532)

 Number of Briefs: _____ Per ☐ **Month**

 _____ **Incontinence Pads (Liners)/each** (T4535) **Start Date:** _____

 Number of Pads: _____ Per ☐ **Month**

 _____ **Under pads/case** (A4554) **Start Date:** _____

 Number of Cases: _____ Per ☐ **Month**

 _____ **Wipes/box** (T5999) **Start Date:** _____

 Number of boxes: _____ Per ☐ **Month**

 _____ **Gloves/1box** (A4927) **Start Date:** _____

Case Manager/Early Interventionist: Name / Address / Phone # (Please Print):

Signature of Person Authorizing Services

COMMUNITY SUPPORTS Form IS-3

Date